Health Information and Quality Authority
Social Services Inspectorate

Registration Inspection report
Designated Centres under Health Act 2007

Centre name:	Sacre Coeur Nursing Home
Centre ID:	0278
Centre address:	Station Road Tipperary Co Tipperary
Telephone number:	062 51157
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Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered provider:	Sacre Coeur Nursing Home Ltd
Person authorised to act on behalf of the provider:	Selma Kelly
Person in charge:	Laura Myers
Date of inspection:	20 October 2011 and 21 October 2011
Time inspection took place:	**Day-1 Start:** 10:15hrs **Completion:** 19:30hrs **Day-2 Start:** 09:45hrs **Completion:** 18:30hrs
Lead inspector:	Mary Moore
Support inspector(s):	Catherine O'Keeffe
Type of inspection:	☒ **Registration** ☒ **Announced** ☐ **Unannounced**

About registration

The purpose of regulation is to protect vulnerable people of any age who are receiving residential care services. Regulation gives confidence to the public that people receiving care and support in a designated centre are receiving a good, safe, service. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Under section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

As part of the registration process, the provider must satisfy the Chief Inspector that s/he is fit to provide the service and that the service is in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended).

In regulating entry into service provision, the Authority is fulfilling an important duty under section 41 of the Health Act 2007. Part of this regulatory duty is a statutory discretion to refuse registration if the Authority is not satisfied about a provider's fitness to provide services, or the fitness of any other person involved in the management of a centre. The registration process confirms publicly and openly that registered providers are, in the terminology of the law, "fit persons" and are legally permitted to provide that service.

Other elements of the process designed to assess the provider's fitness include, but are not limited to: the information provided in the application to register, the Fit Person self-assessment, the Fit Person interviews, findings from previous inspections and the provider's capacity to implement any actions as a result of inspection.

Following the assessment of these elements, a recommendation will be made by inspectors to the Chief Inspector. Therefore, at the time of writing this report, a decision has not yet been made in relation to the registration of the named service.

The findings of the registration inspection are set out under eighteen outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended); the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Resident's comments are found throughout the report.

The registration inspection report is available to residents, relatives, providers and members of the public, and is published on www.hiqa.ie in keeping with the Authority's values of openness and transparency.

About the centre

Location of centre and description of services and premises

Sacre Coeur Nursing Home is located just on the outskirts of Tipperary Town and is within reasonable walking distance of the town centre. The premises was originally constructed in 1911 and functioned as a convalescence facility for military personnel. It has been family owned and managed as a nursing home since 1983. The original premises is two storey with a further two storey extension added in the early 2000s. Resident accommodation is provided on both floors in both the old and new elements of the building.

The main entrance offers both pedestrian and wheelchair access. Ground floor accommodation consists of the main dining room, communal room, visitors' room, treatment room, main kitchen and ancillary areas, sluice room and a bathroom containing toilet, wash-hand basin, floor level bath and assisted shower. Eleven residents are accommodated on the ground floor in three single bedrooms none of which are en suite, two single bedrooms each with en suite toilet, wash-hand basin and assisted shower and two three-bedded bedrooms neither of which are en suite.

The first floor is split level and accessed by means of a stairwell and a stairs chair-lift is provided. Six residents are accommodated at the lower level in three twin-bedded rooms none of which are en suite. A bathroom with toilet, wash-hand basin and assisted shower is conveniently located to these three bedrooms. Staff, administration and storage areas are also accessed from this level.

There is a turn in the stairwell (also serviced by the stairs chair-lift) that leads to the nurses' station and five further bedrooms, one single and four twin-bedded rooms none of which are en suite. A further bathroom with toilet, wash-hand basin and assisted shower is within easy access of these bedrooms.

The laundry, storage and cleaning store are sited in an external building.

The premises is located on a mature, secure, well maintained site with a spacious attractively landscaped garden with pathways, patio and seating areas. The site offers very limited parking and parking for staff and visitors is primarily accommodated by means of roadside parking.

In total 26 residents can be accommodated and long-term, respite and palliative care is provided. On the day of inspection there were 25 residents living in the centre all of whom were in receipt of long-term care. Sixteen residents were greater than 80 years of age, two residents were less than 60 years of age and eight residents had a diagnosed dementia.

Date centre was first established:			1983	
Number of residents on the date of inspection:			25	
Number of vacancies on the date of inspection:			1	
Dependency level of current residents:	Max	High	Medium	Low
Number of residents	10	4	6	5
Gender of residents			Male (✓)	Female (✓)
			9	16

Management structure

Sacre Coeur Nursing Home is owned and managed by Sacre Coeur Nursing Home Ltd., of which there are two directors, Selma Kelly the nominated Registered Provider and Laura Myers the Person in Charge. Both directors are employed fulltime in the centre and have owned and managed the service since July 2009. Laura Myers is assisted and supported in her role by the Key Senior Manager Lelia Considine, who has extensive clinical and managerial experience of the service. A team of nursing staff, care staff, catering staff, cleaning staff, the activities coordinator and administration staff attend to the social and care needs of the residents and the operation of the service on a daily basis.

Summary of compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

This report set out the findings of a registration inspection, which took place on 20 October 2011 and 21 October 2011 following an application to the Health Information and Quality Authority for registration under Section 48 of the Health Act 2007. This inspection was the second inspection of Sacre Coeur Nursing Home by the Health Information and Quality Authority.

The centre's first inspection was an unannounced one day regulatory monitoring visit on 26 August 2010 to focus on key regulatory requirements for centres that had not previously been inspected by the Authority. On that occasion the inspector was satisfied that the providers were involved in the day-to-day running of the centre and demonstrated a clear commitment to delivering a quality service to residents. The location of the centre enabled residents to maintain social contacts with the local community and the involvement of relatives and the wider community was encouraged. Residents spoken with were satisfied with their quality of life and were complimentary about the staff. The premises were found to be very clean and well equipped. There were some areas which required improvement. These included: an overall policy and procedure for effective risk management was not in place, a fully comprehensive fire safety register was not maintained, best practice guidelines were not strictly adhered to regarding the use of restraint, some improvements to the premises were required.

On this second inspection inspectors met with residents, relatives, and staff members over the two day inspection. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, complaints records, fire safety and risk management records and staff files. Separate fit person interviews were carried out with the nominated provider and the person in charge, both of whom had completed the Fit Person self-assessment document in advance of the inspection. This was reviewed by inspectors, along with all the information provided in the registration application form and supporting documentation.

The inspectors were satisfied that the nominated registered provider and the person in charge had a sound understanding of and a commitment to meeting their responsibilities as prescribed in the Health Act 2007 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. There was supporting evidence to validate their objective of providing safe, quality, person-centred services to the residents. Where issues had arisen that had the potential to compromise the quality and safety of the services, inspectors found evidence that these issues were managed and dealt with proactively by the providers. Residents and relatives again reported a high level of satisfaction with the staff and the care and services provided. Overall the inspectors were satisfied that the residents' safety and well being was central to the ethos of service delivery. There was an awareness of and a commitment to ongoing review

and continuous improvement with formalised systems of review in place many of which used the *National Quality Standards for Residential Care Settings for Older People in Ireland* as a framework and benchmark for care and practice. There was evidence of improvements made since the last inspection particularly in relation to risk management, the management of complaints, restraint, fire safety, care planning, recruitment practices, and the cultivation of a person-centred approach to care and service provision.

Further improvements were required however to enhance the many findings of good practice and further compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland* . These required improvements are set out in detail in the Action Plan at the end of this report and include:

- adequate and appropriate staffing at all times
- staff training including mandatory training
- the design and layout of the premises
- receipting processes for the management of residents' monies or other valuables.

Section 50 (1) (b) of the Health Act 2007

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. Statement of purpose and quality management

Outcome 1
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the statement of purpose, and the manner in which care is provided, reflect the diverse needs of residents.

References:
Regulation 5: Statement of Purpose
Standard 28: Purpose and Function

Inspection findings

A comprehensive, legislatively compliant statement of purpose and function was in place. It was an accurate description of the service and facilities provided including any challenges posed by the design and layout of the premises and the systems in place to safely manage those challenges such as pre-admission and admission procedures and the ongoing management of increased dependency or care requirements for existing residents.

Outcome 2
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

References:
Regulation 35: Review of Quality and Safety of Care and Quality of Life
Standard 30: Quality Assurance and Continuous Improvement

Inspection findings

The nominated registered provider and the person in charge were present in the centre on a full-time basis and available to take requests and feedback from residents and relatives on a daily basis. Formal systems for reviewing the quality, safety and appropriateness of the care and services provided were also in place. The inspector reviewed audits completed in consultation with an external consultant as part of a quality and safety management system using the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland* as a benchmark for evaluation. There was

evidence of remedial actions taken as a result of the review process such as the introduction of a new system of care planning augmented by staff training. Falls were reviewed individually and collectively on a quarterly basis by the person in charge with evidence of the identification of remedial actions such as the removal of environmental hazards and monitoring staff adherence to the reassessment of fall risk after each fall.

The inspector also saw records such as staff meetings where issues identified through monitoring care, practice and work performance were addressed and appropriate remedial action taken.

Outcome 3
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

References:
Regulation 39: Complaints Procedures
Standard 6: Complaints

Inspection findings

Senior nursing staff were known by name to the residents who, when spoken with and in their completed questionnaires, told the inspector that they would feel comfortable and confident in approaching staff if they had any concerns or complaints. Complaints records reviewed by the inspector confirmed this and supported a culture of care that was receptive to complaints, where complaints were listened to, and where residents and relatives felt free and secure in expressing their concerns or dissatisfaction with aspects of their daily care and routine. Complaints records were comprehensive and outlined the investigation of each complaint, actions taken and an evaluation of complainant satisfaction. The complaints policy and procedure had been revised in August 2011, it satisfied the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and it was clearly displayed in the main entrance lobby.

The provider was progressing the introduction of an advocacy service for residents and at the time of the inspection; she told the inspectors that a suitable advocate had been sourced.

2. Safeguarding and safety

Outcome 4
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

References:
Regulation 6: General Welfare and Protection
Standard 8: Protection

Standard 9: The Resident's Finances

Inspection findings

Residents reported feeling safe and told inspectors that they had "no worries"; they attributed their sense of safety to the security of the physical environment and the continuous presence of staff. Relatives' responses prioritised the physical safety of the environment.

Inspectors reviewed documentation confirming that the provider and person in charge monitored complaints, care practices and behaviours in the centre to ensure safe and respectful care for residents. The person in charge and the KSM were visible and seen to be directly involved in the supervision of residents and the delivery of their care. A centre-specific policy on the prevention, detection and management of abuse was in place and staff spoken with were clear as to what constituted abuse and their reporting responsibilities. However, staff files and staff training records did not confirm that all staff, particularly newly recruited staff had received education and training on the prevention, detection and response to alleged or suspected abuse.

Computerised records were available for inspection detailing the management of financial charges to residents and monies paid by or in respect of each resident.

Improvements were required, however, in the recording and receipting processes where monies and/or valuables were kept and managed for safekeeping by the provider at the request of the resident. Likewise while staff completed inventories of residents' monies and personal possessions on admission these were not all signed by the resident or the responsible family member.

Outcome 5
The health and safety of residents, visitors and staff is promoted and protected.

References:
Regulation 30: Health and Safety
Regulation 31: Risk Management Procedures
Regulation 32: Fire Precautions and Records
Standard 26: Health and Safety
Standard 29: Management Systems

Inspection findings

While improvements were required overall inspectors were satisfied that the providers had an ongoing proactive approach to managing safety and had taken measures to enhance and promote the safety of residents, staff and visitors.

An external consultant had been engaged to review and compile a risk management policy and undertake risk assessments of the premises and service. A

broad range of risk assessments relating to residents and resident care, the physical environment , staffing and work practices had been completed, were centre-specific and there was evidence of review and implementation of required controls by the provider. However, the revised risk management policy requires further modification as it did not:

- encompass the identification and assessment of risks for all areas of work and work practices throughout the designated centre
- all of the precautions in place to control risks specific to the design and layout of the premises such as the stairwell and the stairs chair-lift.

An emergency plan was in place providing clear instructions for staff on the actions to be taken in the event of emergencies such as loss of power, water, sudden death, injury or breach of security. Arrangements were in place for the alternative accommodation of residents in the event of a required evacuation of the premises.

There was evidence of the proactive management of fire prevention and safety implemented on a daily basis by staff. Records reviewed stated that staff undertook training in the prevention and management of fire including simulated evacuation drills in September 2010, April, May and October 2011. Staff spoken with confirmed their attendance at training and described the procedures to be followed in the event of evacuation. Two fire evacuation chairs were in place, one on each of the first floor levels; each level was also directly served by an external fire escape. Each resident had a personal emergency evacuation plan (PEEP) that was reviewed on a weekly basis. Servicing certificates were in place annually for all fire fighting equipment, the emergency lighting and the fire detection system. The fire detection system was also inspected and tested on a quarterly basis. The inspector reviewed documentation stating that the fire detection system had been upgraded from an L3 to an L1 system. Staff undertook and maintained records of daily checks of the fire alarm panel, fire escape routes, PEEP's and emergency equipment.

Staff were seen to have access to adequate and appropriate personal protective equipment and a colour coded system of cleaning was in place to assist in the prevention and control of infection. Staff spoken with who had responsibility for environmental hygiene and the management of infected or soiled laundry were knowledgeable as to the implementation of accepted best practice in the prevention and control of infection. Access was restricted to clinical risk waste storage areas and consignment notes for the removal of such waste were available for inspection. A bedpan washer was in place and operational further to the required actions of the last inspection.

The kitchen and food storage areas were clean, tidy and organised and there was evidence of the implementation of the Hazard Analysis and Critical Control Points (HACCP) food safety management system. The kitchen was inspected by the relevant Environmental Health Officer (EHO) and reports reviewed demonstrated that the service was substantially compliant with the relevant food safety legislation.

Lifting devices for use by staff when moving dependent residents were in place and had been serviced in June 2011. A resident sit-stand hoist had recently been

purchased. Training records confirmed that staff had attended education and training on manual handling and moving techniques in patient care in May 2011 and September 2011. However staff training records and staff files did not collectively confirm that all staff employed had been trained in the moving and handling of residents.

Outcome 6
Each resident is protected by the designated centres' policies and procedures for medication management.

References:
Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines
Standard 14: Medication Management

Inspection findings

While improvements were required, the inspectors were satisfied that nursing staff had a sound understanding of safe medication management practices, professional guidelines and regulatory body requirements. Inspectors saw evidence to support robust routine systems for monitoring and reviewing all medications prescribed and supplied to residents; medication management audits and assessments of nursing staffs' medication management competencies were undertaken by the person in charge. Each care plan reviewed contained documentary evidence of the three-monthly reviews of each residents prescribed medications.

The required improvements related to the implementation of policy in practice and the development of further specific policy as follows:

- there was no centre-specific policy for the prescribing, administration and review of PRN (*pro-re-nata)* medication, (medication that is not scheduled or required on a regular basis)
- staff did not at all times adhere to the centre-specific policy for the stock balance checking of controlled drugs.

3. Health and social care needs

Outcome 7
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

References:
Regulation 6: General Welfare and Protection
Regulation 8: Assessment and Care Plan

Regulation 9: Health Care
Regulation 29: Temporary Absence and Discharge of Residents
Standard 3: Consent
Standard 10: Assessment
Standard 11: The Resident's Care Plan
Standard 12: Health Promotion
Standard 13: Healthcare
Standard 15: Medication Monitoring and Review
Standard 17: Autonomy and Independence
Standard 21: Responding to Behaviour that is Challenging

Inspection findings

Inspectors were satisfied that the health and wellbeing of each resident was maintained and supported on a daily basis by a high standard of nursing and medical care. This was confirmed by residents and relatives who articulated a high level of satisfaction with the staff and the care delivered. Many residents spoken with confirmed that they retained the services of their own general practitioner (GP) and they were knowledgeable and informed as to their health and prescribed treatments. Medical records reviewed demonstrated that residents had access to timely medical review in response to established or evolving needs; accident and incident records confirmed that a responsive out-of-hours medical service was available. Inspectors saw evidence to support referral and access to specialist services/allied health care professionals in line with and as appropriate to the needs of residents such as occupational therapy, chiropody and podiatry, dieticians, speech and language therapy, physiotherapy, tissue viability and dental services.

There was further evidence to support that healthcare, while responsive, was also proactive and focused on promoting health. Residents' vital signs and weight were monitored monthly and any deficits (including weight gain) were acted upon. Residents as appropriate had recently received influenza vaccination and blood profiling and laboratory evaluation was undertaken as a means of evaluating and monitoring health.

The person in charge undertook explicit pre-admission assessments as outlined in the centre-specific admission policy and clearly understood the requirement for a robust assessment process. The person in charge had also recently undertaken a full review of the process of care planning, introduced new care plans for each resident and augmented the change process with education and training for nursing staff and the introduction of a key nurse system. A sample of care plans reviewed were individualised and person-centred, were supported by a suite of evidence based assessment tools and care plans were developed appropriate to the resident's assessed needs. The clinical dimension of the care plans was supplemented and complemented by an informative demographic and personal profile of each resident.

Restraint records reviewed by inspectors supported that staff were committed to striking a balance between safety, risk and personal choice. Inspectors saw that

independence and mobility were promoted and where bedrails, lap-belts, or chairs with a tilt facility were in use, practice was supported by a clinical rationale, specific risk assessments, occupational therapy referral and review, formalised discussion and agreement with the resident and other relevant stakeholders, and records of monitoring, release and opportunity for motion were maintained. Inspectors saw documentary evidence confirming the monitoring of practice and the provision of comprehensive evidenced-based education to staff on the management of challenging behaviours.

Staff spoken with clearly understood the therapeutic benefit of providing meaningful, purposeful and person-centred engagement and occupation for residents. A dedicated activities coordinator was employed and the schedule of activities was clearly displayed. The activities programme was informed by the completion of a pool activity level assessment for each resident; a formal assessment tool to design and implement an individualised meaningful activity programme to meet residents social and psychological needs. Inspectors saw that devised interventions were implemented in practice. Staff were in the process of completing life story books with residents and families and one resident took great joy in sharing hers with the inspector.

Improvement was required in relation to the provision of contemporary evidence-based and nationally agreed policy to underpin wound prevention and wound management practice to ensure a high standard of contemporary evidence-based nursing practice and the best possible clinical outcomes for residents. Deficiencies were noted in policy and practice in relation to an objective evidence-based decision-making framework for the provision of pressure-relieving equipment to residents following an assessment of risk.

Outcome 8
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

References:
Regulation 14: End of Life Care
Standard 16: End of Life Care

Inspection findings

The environment posed some challenges to choice, privacy and dignity at end of life insofar as that nine of the fourteen available bedrooms were shared and staff spoken with confirmed that it was not always possible to facilitate or provide single accommodation. Staff also reported, however, how supportive relationships developed between residents in shared accommodation and end of life was often seen by them as a normal transition in that relationship and one they wished to share. Relatives spoken with who had experienced the end-of-life care provided by staff positively recounted their experience of the care provided to their family member and the extended family. Access to specialist palliative care services was

available and facilitated as appropriate to the individual resident's needs. Twelve staff had attended palliative care education in the centre in August 2011. A sample of care plans reviewed demonstrated that staff were proactive and planned ahead for end of life including explicit discussions in relation to resuscitation in the event of unanticipated death.

Outcome 9
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

References:
Regulation 20: Food and Nutrition
Standard 19: Meals and Mealtimes

Inspection findings

Clinical and catering staff spoken with were knowledgeable as to the preferences and dietary requirements of residents and there were appropriate systems in place for monitoring each individual resident's dietary intake. Nursing staff had implemented the Malnutrition Universal Screening Tool (MUST); nutritional care plans were in place as required as was consultation and referral to nutritional services. Inspectors saw that catering staff had available to them adequate and varied stocks of fresh, frozen and dried food products delivered on a regular basis, and meals were freshly prepared by them on a daily basis. Catering staff maintained nutritional and dietary documentation on each resident that was updated as required by nursing staff; catering staff spoken with were familiar with the documentation and readily retrieved the required information for the inspector. Minutes of regular meetings between catering staff and the person in charge were also reviewed by the inspector, with evidence of review of the menu and meal choices based on feedback from residents and monitoring of the popularity of available meal choices.

Inspectors saw that residents were offered a varied and nutritious diet, snacks and beverages throughout the day. Staff were seen to individually ask each resident their preferred meal choice; one resident was noted to reflect on and change his choice and actively brought this to the attention of the staff. Adequate and appropriate supervision was in place and where assistance was required it was discreetly provided. One resident took her meals in her own bedroom but clearly told the inspector that this was her own choice. Residents and relatives expressed satisfaction with the variety and quality of the meals provided which they described as "first class".

4. Respecting and involving residents

Outcome 10
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

References:
Regulation 28: Contract for the Provision of Services
Standard 1: Information
Standard 7: Contract/Statement of Terms and Conditions

Inspection findings

Inspectors saw that each resident had a contract of care that set out the details of the services to be provided, the fees to be charged for such services and details of services provided outside of the fee and the payment arrangements for such services. They were a standard form of contract; however, and a sample reviewed did not explicitly state the specific contract status that was applicable to each resident and the precise charge for which the resident was individually liable for.

Outcome 11
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.

References:
Regulation 10: Residents' Rights, Dignity and Consultation
Regulation 11: Communication
Regulation 12: Visits
Standard 2: Consultation and Participation
Standard 4: Privacy and Dignity
Standard 5: Civil, Political, Religious Rights
Standard 17: Autonomy and Independence
Standard 18: Routines and Expectations
Standard 20: Social Contacts

Inspection findings

Based on their observations, documentation reviewed and the fit-person interviews completed, the inspectors were satisfied that the resident was at the centre and focus of care and service delivery.

Relatives described staff as "very friendly" and the atmosphere as "relaxed and homely". Relatives observed that staff interacted with residents with "time and encouragement". Residents told inspectors that the staff were "great" and described having choice and flexibility in their daily routine. Inspectors saw that care was delivered in an individualised manner and that the nominated provider and the person in charge had taken constructive and ongoing action to change entrenched and task-orientated work practices particularly in relation to restraint, encouraging independence and mobility, and the management of challenging behaviours. This respect for individuality and personhood was further reflected in

the physical environment, in the general standard of décor and the personalisation of residents' bedrooms.

Nursing and care staff were noted by inspectors to be visible at all times and residents were at ease in their company. Bedroom and bathroom doors were closed while staff delivered personal care and discreet advisory notices were placed on doors thereby further protecting the privacy of residents.

The residents' committee that was previously reported by the provider to have not been a success had recently been re-established. The inspector reviewed the minutes of the meeting held in September 2011 that was attended by 14 residents and four relatives. A broad range of topics were discussed such as activities, scheduled social outings and the quality of the meals. Residents gave positive feedback on the new seating arrangements in the communal room that were described as "homely and welcoming". The provider and person in charge reassured the inspector that they would make every effort to continue the committee and that it worked best on an informal basis. The provider was currently working on a feedback questionnaire for distribution to both residents and relatives.

Documentation reviewed by the inspector pertaining to the review and management of complaints, accidents and incidents and nursing records, attested to the registered providers' belief in the resident's right to exercise personal autonomy, choice and self-determination within a reasonable and safe risk management framework.

Inspectors saw that residents had good access to newspapers, televisions, radios and mobile phones. There was evidence of reminiscence-themed interventions and memorabilia that staff used to initiate conversation and communication with cognitively impaired residents.

Residents were satisfied that their religious and spiritual needs were well attended to, mass took place in the centre and again staff were seen to utilise religious themed CDs on an individualised basis for more dependent residents.

Given the urban location of the centre it was easily accessed by visitors and family members and a high level of visiting activity was noted by the inspectors. A pleasant and private room was available to residents and their visitors. Residents told the inspector that they retained and enjoyed good family and social relationships. As appropriate to their needs residents had access to local day care and rehabilitation services; a personal assistant had recently been secured for one resident.

Outcome 12
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

References:
Regulation 7: Residents' Personal Property and Possessions
Regulation 13: Clothing
Standard 4: Privacy and Dignity
Standard 17: Autonomy and Independence

Inspection findings

The on-site laundry was clean, tidy, organised and appropriately equipped with clearly displayed instructions for staff in relation to the management of linen and residents' personal clothing; an external ironing service was utilised. Inspectors noted that residents were assisted to maintain a high standard of personal grooming and residents spoken with confirmed that staff "cared well" for their personal clothing and belongings. Another resident told the inspector that staff had encouraged her to bring some personal belongings with her on admission and she enjoyed using her own quilt on her bed. Shared bedrooms provided adequate segregated storage space for each resident.

5. Suitable staffing

Outcome 13
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

References:
Regulation 15: Person in Charge
Standard 27: Operational Management

Inspection findings

The person in charge worked as Director of Nursing since July 2009 but has further experience of working in the centre as both a staff nurse and nurse manager from January 2006 to July 2009. She is a registered children's nurse and a registered general nurse.

As one of two directors of Sacre Coeur Nursing Home Ltd, she has enhanced authority, responsibility and accountability for the governance, operational management and administration of the centre. The inspection findings and improvements made as outlined in the report support the judgement of the inspector that she has the required skills, knowledge and competencies to fulfil the role of person in charge to a good standard. She had a sound understanding of her responsibilities as prescribed in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended), and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

The person in charge demonstrated evidence of continuing professional development to assist her in exercising her clinical and managerial responsibilities

and had completed education and training such as risk management, understanding and managing challenging behaviours, fire safety, infection prevention and control and manual handling. She successfully completed in 2010 Gerontological education to FETAC (Further Education and Training Awards Council) Level 6.

She was supported in her role on a daily basis by the nominated registered provider who also worked full-time in the centre, and by the KSM. The KSM is a registered general nurse and has extensive experience of assuming responsibility for the care and services having previously worked as the person in charge of the centre.

The person in charge was described as available, approachable and "helpful" by residents and relatives spoken with.

Outcome 14
There are appropriate staff numbers and skill-mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

References:
Regulation 16: Staffing
Regulation 17: Training and Staff Development
Regulation 18: Recruitment
Regulation 34: Volunteers
Standard 22: Recruitment
Standard 23: Staffing Levels and Qualifications
Standard 24: Training and Supervision

Inspection findings

While there was evidence to support positive and proactive staff recruitment and ongoing staff management practices, improvements were required.
Staff files were substantially complete and contained all of the information as prescribed by the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Many references reviewed by the inspector; however, were of a testimonial type and there was no evidence to support their verification by the registered provider.

Evidence of current registration with their regulatory body An Bord Altranais was in place for each nurse employed.

At the time of inspection the registered provider was in the process of compiling an overall matrix of staff training completed. Records reviewed by the inspector confirmed that to date in 2011 staff had undertaken education and training in manual handling, elder abuse, fire safety and evacuation, missing-persons drill,

food hygiene and safety, safe handling of chemicals, palliative care and medication management. There was evidence to support that the needs of the residents and gaps identified by staff informed the content of the staff education programme. The inspector reviewed documentation including minutes of staff meetings and staff appraisals, confirming that further manual handling training and a comprehensive dementia/challenging behaviours and objective record keeping education programme had been facilitated in response to identified service needs. However, it was not possible to definitively establish that all staff, including newly recruited staff had completed mandatory training such as manual handling and the prevention, detection and response to elder abuse.

Many staff spoken with had extensive experience in the centre and spoke positively of their work. Staff spoken with were knowledgeable as to their roles, responsibilities and reporting relationships and the care requirements of the residents. Staff were seen to be attentive to the needs of residents and appropriately supervised by key nursing personnel. There was a clear organisational structure in place. Staff confirmed the completion of induction training at the commencement of employment and a staff appraisal system, though not fully complete, was in place with evidence to support that appraisals were completed in a phased and constructive manner and suitable arrangements were put in place to address identified gaps or training requirements. Staff had knowledge commensurate with their roles of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*. Regular staff meetings were convened and minutes reviewed demonstrated comprehensive discussion and actions taken on issues directly relevant to the quality and safety of services provided to residents.

While an objective validated tool was used by the person in charge to determine staffing levels, inspectors were not satisfied that sufficient staff were at all times employed as appropriate to the assessed dependency and care needs of the residents, the layout of the premises and the accessibility of services. This was confirmed by a review of the calculations achieved by the staffing tool applied and a review of the staff rosters; the latter confirmed a weekend staffing deficit.

6. Safe and suitable premises

Outcome 15
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

References:
Regulation 19: Premises
Standard 25: Physical Environment

Inspection findings

The premises, a period building, had been maintained to a high standard and presented as a secure, welcoming and comfortable care environment. It was appropriately, heated, lighted and ventilated and in excellent decorative order throughout. However, because it was not purpose-built, its design and layout presented challenges to meeting the individual and collective needs of all residents. Bedrooms and services on the first floor were accessed by means of the stairwell or the stairs chair lift. These limitations were acknowledged by the registered provider and measures to manage them were in place.

The person in charge was knowledgeable as to the restrictions posed by elements of the building, the requirement to manage on an ongoing basis these restrictions and the challenges they posed to the quality and safety of the care and services provided, particularly in relation to admissions, placement, and relocation of residents to the ground floor as necessary. Eight of the ten residents assessed as maximum dependency at the time of the inspection were accommodated on the ground floor. Staff had been provided with walkie-talkies and were seen to utilise these to communicate with each other or to seek assistance between floors. Staff were observed to undertake regular physical checks of residents and their location.

Furnishings and fittings were of a high standard and appropriately maintained. Service contracts for equipment such as wheelchairs, beds, pressure-relieving mattresses and lifting devices were in place and reviewed by the inspector. Services such as gas, heating and water were all inspected in 2011 and thermostatically controlled valves had been installed in the main bathrooms.

Residents had access to secure external grounds that were attractively planted and maintained to a high standard; adequate and strategically located seating was available. Access and egress of the premises and grounds was controlled by electronic keypad.

Residents' bedrooms were accommodated on both ground and first floor levels. Bedrooms were attractively and respectfully personalised and bed spaces in shared bedrooms were appropriately screened. One twin-bedded room and one three-bedded room did not meet the room size criteria laid down by the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Only two of the 15 bedrooms are en suite and the remaining 24 residents had access to three full bathrooms; wash-hand basins were provided in each bedroom. Collectively insufficient toilets were provided for the number of residents accommodated and availability was compounded by the location of the toilets. The one available toilet on the ground floor was not conveniently located to residents' bedrooms or the dining and communal areas. The first floor bathrooms while conveniently located to residents' bedrooms on this floor were not conveniently located or easily accessed by more dependent residents from the ground floor. Practical daily difficulties in relation to access and availability of toilets were confirmed by residents spoken with and documentation reviewed by inspectors in relation to toileting practices.

Though comfortable and of a high decorative standard, inadequate sitting, dining and recreational space was provided.

Architectural plans for the extension of the premises and the provision of a passenger lift to address the limitations of the current service in line with the provisions of the *National Quality Standards for Residential Care Settings for Older People in Ireland* were made available to the inspectors.

Suitable staff facilities were available.

Residents and relatives had access to a suitable and separate private area for visiting if they so wished.

Bathrooms and circulation areas were well equipped with handrails and grab-rails.

7. Records and documentation to kept at a designated centre

Outcome 16
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

References:
Regulation 21: Provision of Information to Residents
Regulation 22: Maintenance of Records
Regulation 23: Directory of Residents
Regulation 24: Staffing Records
Regulation 25: Medical Records
Regulation 26: Insurance Cover
Regulation 27: Operating Policies and Procedures
Standard 1: Information
Standard 29: Management Systems
Standard 32: Register and Residents' Records

Inspection findings
** Where "Improvements required" is indicated, full details of actions required are in the Action Plan at the end of the report.*

Resident's Guide

Substantial compliance ☒ Improvements required* ☐

Records in relation to residents (Schedule 3)

Substantial compliance ☒ Improvements required* ☐

General records (Schedule 4)

Substantial compliance ☐ Improvements required* ☒

Improvements as outlined in the main body of the report were required in the logging and receipting of residents' personal money, valuables and property.

Operating policies and procedures (Schedule 5)

Substantial compliance ☐ Improvements required* ☒

Improvements as outlined in the main body of the report were required in medication management policy, wound prevention and management policy, and risk management policy.

Directory of residents

Substantial compliance ☒ Improvements required* ☐

Staffing records

Substantial compliance ☐ Improvements required* ☒

Improvements as outlined in the main body of the report were required in the verification of staff references and the completeness of staff training/staff training records.

Medical records

Substantial compliance ☒ Improvements required* ☐

Insurance cover

Substantial compliance ☒ Improvements required* ☐

Outcome 17
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

References:
Regulation 36: Notification of Incidents
Standard 29: Management Systems

Standard 30: Quality Assurance and Continuous Improvement
Standard 32: Register and Residents' Records

Inspection findings

Comprehensive individual records of accidents and incidents were maintained. Each record reviewed by the inspector contained the information as outlined in Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Each accident and incident was managed and responded to and where appropriate medical review and referral was sought. There was evidence to support that each accident/incident was reviewed by either the person in charge or the provider, required improvements were identified and acted upon, feedback was provided to staff for learning, to prevent reoccurrence and improve clinical and safety outcomes for residents.

The person in charge had fully exercised her responsibility in relation to the submission of notifications to the Chief Inspector. Quarterly returns to the Chief Inspector as well as notification of serious injury were submitted.

Outcome 18
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

References:
Regulation 37: Notification of periods when the Person in Charge is absent from a Designated Centre
Regulation 38: Notification of the procedures and arrangements for periods when the person in charge is absent from a Designated Centre
Standard 27: Operational Management

Inspection findings

There had been no expected or unexpected absence of the person in charge of a duration that required notification to the Chief Inspector. The person in charge and the nominated provider were aware of the notification requirements.

Closing the visit

At the close of the inspection visit a feedback meeting was held with the nominated registered provider and the person in charge to report on the inspectors' findings, which highlighted both good practice and where improvements were needed.

Acknowledgements

The inspectors wish to acknowledge the cooperation and assistance of the residents, relatives, provider and staff during the inspection.

Report compiled by:

Mary Moore
Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

8 November 2011

Health Information and Quality Authority
Social Services Inspectorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report*

Centre:	Sacre Coeur Nursing Home
Centre ID:	0278
Date of inspection:	20 October 2011 and 21 October 2011
Date of response:	28 November 2011

Requirements

These requirements set out the actions that must be taken to meet the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care settings for Older People in Ireland*.

Outcome 4: Safeguarding and safety

1. The provider is failing to comply with a regulatory requirement in the following respect:

Staff training records did not confirm that all staff had received education and training on the prevention, detection and response to alleged or suspected elder abuse.

Improvements were required in the recording and receipting processes where monies and/or valuables were kept and managed for safekeeping by the provider at the request of the resident.

Action required:

Make all necessary arrangements, by training all staff and by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Action required: Maintain a record of all monies and valuables held on behalf of or received on the resident's behalf and monies returned or given to third parties on the resident's behalf. Records shall contain all of the documentary requirements as listed in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Best practice recommends that in the interest of transparency, accountability and the safeguarding of all parties, transactions should be witnessed and co-signed by two staff members and where possible the resident.	
Reference: Health Act 2007 Regulation 6: General Welfare and Protection Standard 8: Protection Standard 9: The Resident's Finances	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The records of all staff have been reviewed. Any staff members who had not received elder abuse training have been identified and training will be provided within four weeks. The processes for managing residents' monies have been reviewed. Where monies or valuables are held on behalf of or received on the resident's behalf and monies returned or given to third parties on the resident's behalf, this is documented in a new separate receipt book. All transactions are witnessed and co-signed by two staff members and where possible the resident. Receipts are provided to residents for all transactions.	20 December 2011 20 December 2011

Outcome 5: Health and safety and risk management

2. The provider is failing to comply with a regulatory requirement in the following respect: The revised risk management policy did not encompass the identification and assessment of risks for all areas of work and work practices throughout the designated centre. Staff training records and staff files did not collectively confirm that all staff employed had been trained in the moving and handling of residents.
Action required: Ensure that the risk management policy covers, but is not limited to, the identification

and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.	
Action required: Provide training for all staff in the moving and handling of residents. Maintain accurate records of all mandatory training provided.	
Reference: Health Act 2007 Regulation 31: Risk Management Procedures Standard 26: Health and Safety Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The risk management policy is being reviewed to ensure identification and assessment of all risks and the precautions in place to control these risks. This will include specific detail regarding risk assessments for specific equipment within the home. All staff that have not had moving and handling training have been identified. Moving and handling training is scheduled to be provided to these staff. Records of the training will be stored within the staff files.	 20 December 2011 20 December 2011

Outcome 6: Medication management

3. The provider is failing to comply with a regulatory requirement in the following respect: • there was no centre-specific policy for the prescribing, administration and review of PRN (*pro re nata)* medication (medication that is not scheduled or required on a regular basis) • staff did not at all times adhere to the centre-specific policy for the stock balance checking of controlled drugs.
Action required: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the prescribing, administration and review of PRN medications and ensure staff are familiar with such procedures and policies.

Action required: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the checking and stock balance checking of controlled drugs and ensure staff are familiar with and adhere to such procedures and policies.	
Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: A specific section detailing the processes to be followed when administering PRN medications has been incorporated into medication policy and procedure reference HS-006 Administration of Medication. This outlines the specific processes for prescribing, administration and review of PRN medications. All nursing staff shall receive education on PRN policy and procedure and shall be required to sign acknowledgement of receipt of same. The Director of Nursing has spoken with nursing staff in relation to the management of controlled drugs. Additional training shall be scheduled with the pharmacy in early 2012. The policy and procedure on the management of controlled drugs has been revised and re-issued to all relevant staff for sign off and acknowledgement. The Director of Nursing shall undertake regular audit to ensure compliance with the policy and procedure.	 14 December 2011 27 January 2012

Outcome 7: Health and social care needs

4. The provider is failing to comply with a regulatory requirement in the following respect: Wound prevention and wound management practice was not underpinned by contemporary evidence-based and nationally agreed policy to ensure a high standard of contemporary evidence-based nursing practice and the best possible clinical outcomes for residents.
Action required: Put in place appropriate and suitable practices and current evidence-based policy,

procedure and guidelines on wound prevention and management. Ensure that all staff are familiar with and implement such policy.

Action required:

Put in place suitable and sufficient care including therapeutic and assistive devices to maintain each resident's welfare and wellbeing, having regard to the nature and extent of each resident's dependency and needs and in line with a high standard of evidence based nursing practice.

Reference:

Health Act 2007
Regulation 6: General Welfare and Protection
Standard 13: Healthcare
Standard 18: Routines and Expectations

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response:	
The wound management and prevention policy and procedure has been reviewed to include up-to-date evidence-based practice. This has been reissued to all relevant staff for sign off.	9 December 2011
Processes for the management of any resident with an assessed wound risk have been reviewed to ensure that all such residents receive sufficient equipment and devices according to an objective evidence-based decision-making framework and that such processes are documented clearly in the care plan. Where any equipment or devices are required, the decision shall be made to acquire these by the management team.	9 December 2011

Outcome 10: Contract for the provision of services

5. The provider is failing to comply with a regulatory requirement in the following respect:

Contracts of care did not explicitly state the specific contract status that was applicable to each resident and the precise charge for which the resident was individually liable for.

Action required:

Ensure each resident's contract deals with the care and welfare of the resident in the designated centre and includes details of the services to be provided for that resident and the fees to be charged as prescribed by the terms of such contract.

Reference:	
Health Act 2007 Regulation 28: Contract for the Provision of Services Standard 1: Information Standard 7: Contract/Statement of Terms and Conditions	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The contract of care for all residents has been reviewed to ensure it includes details of the services provided for that resident and the fees to be charged.	9 December 2011

Outcome 14: Suitable staffing

6. The person in charge is failing to comply with a regulatory requirement in the following respect: The numbers of staff were not at all times appropriate to the assessed needs of residents, and the size and layout of the designated centre. There was no evidence to support the verification of staff references.	
Action required: Ensure that the numbers and skill mix of staff are at all times appropriate to the assessed needs of residents, and the size and layout of the designated centre.	
Action required: Put in place recruitment procedures to ensure the authenticity of the staff references referred to in Schedule 2.	
Reference: Health Act 2007 Regulation 16: Staffing Regulation 18: Recruitment Standard 22: Recruitment Standard 23: Staffing Levels and Qualifications	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**

Provider's response:	
The weekend staffing deficit has been addressed through the allocation of additional staff during the times identified.	Completed
The recruitment policy and procedure has been updated to ensure that the references for all staff, existing and newly recruited, are authenticated.	Completed

Outcome 15: Safe and suitable premises

7. The provider is failing to comply with a regulatory requirement in the following respect: Elements of the design and layout presented challenges to meeting the individual and collective needs of residents.	
Action required: Provide a sufficient number of appropriately located toilets having regard to the number of dependent residents in the home.	
Reference: Health Act 2007 Regulation 19: Premises Standard 25: Physical Environment	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: The provider has identified a suitable location within the home for an additional ground floor toilet. It is anticipated that these works will be completed by 31 March 2012.	31 March 2012

Any comments the provider may wish to make:

Provider's response:

No response given.

Provider's name: Selma Kelly for Sacre Coeur Nursing Home Limited

Date: 28 November 2011